

FEDERAL BUREAU OF INVESTIGATION
 U.S. DEPARTMENT OF JUSTICE
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-60-019227

FILED VS MAY 16 1960

Registration District No. 141 Primary Registration District No. 3025 Registrar's No. 82

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Monroe</u> b. CITY (If outside corporate limits give TOWNSHIP only) OR TOWN <u>West Plains</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>833 Jefferson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>Monroe</u> c. CITY OR TOWN <u>West Plains</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>833 Jefferson</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Katie Louise Thomas</u>		4. DATE OF DEATH Month Day Year <u>4/23-60</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>7-22-62</u> 9. AGE (last birthday) <u>98</u> IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HR: Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <input checked="" type="checkbox"/> <u>LaCygne, K.S.</u>	
11. BIRTHPLACE (City and state or country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>Joe Allen</u>		13b. MOTHER'S MAIDEN NAME <u>unt</u>	
14. NAME OF HUSBAND OR WIFE <u>Edith Oreal, West Plains Mo</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or date of service) <input checked="" type="checkbox"/>	
16. SOCIAL SECURITY NO. <input checked="" type="checkbox"/>		17. INFORMANT Address <u>Edith Oreal, West Plains Mo</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adenocarcinoma of the uterus</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Arteriosclerotic heart disease</u>			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <u>9/21/59</u> to <u>4/23/60</u> and last saw ^{her} him <u>alive</u> on <u>4/19/60</u> Death occurred at <u>11:15 A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>J. H. Callahan M.D.</u>		22b. ADDRESS <u>West Plains, Missouri</u>	
22c. DATE SIGNED <u>5/9/60</u>		23a. BURLIAC, CREMATION, REMOVAL (Specify)	
23b. DATE <u>4/26-60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Jakey Brown</u>	
23d. LOCATION (City, town, or county) (State) <u>West Plains, Mo</u>		24. FUNERAL DIRECTOR ADDRESS <u>Edith Oreal, West Plains Mo</u>	
25. DATE RECD. BY LOCAL REG. <u>5-11-60</u>		26. REGISTRAR'S SIGNATURE <u>Beatrice Cook</u>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed *D. A. Roberts*

Licensed Embalmer No. 3432

P. O. Address Crested

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to co
with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.